TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
TRUMBULL INSURANCE COMPANY

MFDR Tracking Number
M4-17-3857-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review appeal for untimely denial. . . . Contact was made to the employee and the employer trying to obtain workers comp information. Once received, this claim was immediately billed to Hartford."

Amount in Dispute: $439.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier agreed to process payment on 8/30/17 in the amount of $289.79. Payment processed per Fee & Medicare guidelines for physical therapy."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 2, 2016	Outpatient Hospital Services	$439.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 937 – SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

- 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 18 – DUPLICATE CLAIM/SERVICE
- 306 – BILLING IS A DUPLICATE OF OTHER SERVICES PERFORMED ON SAME DAY

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED; and
   - 937 – SERVICES(S) ARE DENIED BASED ON HB7 PROVIDER TIMELY FILING REQUIREMENT. A PROVIDER MUST SUBMIT A MEDICAL BILL TO THE INSURANCE CARRIER ON OR BEFORE THE 95TH DAY AFTER THE DATE OF SERVICE.

   In the insurance carrier's response, the carrier asserts the services were reprocessed for payment according to division fee guidelines and Medicare payment policies regarding physical therapy. As the above denial reasons were not maintained in the respondent's position statement or on the explanations of benefits (EOBs) accompanying the check, after reprocessing the claim, the division finds that the above denial reasons are no longer in dispute.
2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount for these physical therapy services, provided in a outpatient hospital setting, be multiplied by 200 percent.

   All four billed procedure codes have OPPS payment status indicator A, denoting services paid by fee schedule or different payment system from OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the item on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c).

   All four billed procedure codes represent physical therapy services. Per Medicare policy, when more than one unit of designated therapy services is billed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97110, November 2, 2016, has the highest practice expense for this date. The 2016 Medicare rate for this code is $32.44. Additional units are paid at $24.60. Medicare's rate for 2 units is $57.04. Substituting the DWC conversion factor of 56.82 for the Medicare conversion factor of 35.8279 results in a MAR of $90.46
   - Procedure code 97110, November 7, 2016, has the highest practice expense for this date. The 2016 Medicare rate for this code is $32.44. Additional units are paid at $24.60. Medicare's rate for 2 units is $57.04. Substituting the DWC conversion factor of 56.82 for the Medicare conversion factor of 35.8279 results in a MAR of $90.46
   - Procedure code 97140, November 2, 2016, does not have the highest practice expense for this date. The reduced rate for this code for 2016 is $22.89. Substituting the DWC conversion factor of 56.82 for the Medicare conversion factor of 35.8279 results in a MAR of $36.30
   - Procedure code 97140, November 7, 2016, does not have the highest practice expense for this date. The reduced rate for this code for 2016 is $22.89, multiplied by 2 units is $45.78. Substituting the DWC conversion factor of 56.82 for the Medicare conversion factor of 35.8279 results in a MAR of $72.60
3. The total recommended reimbursement for the disputed services is $289.82. The insurance carrier submitted documentation supporting payment to the provider of $289.79. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.